

Initial Tinnitus Assessment Form



Patient Name: _____

Date of Birth: __ / ____ / ____

Phone Number: _____

Date of Consultation: ____ / ____ / ____

Practitioner: _____

Tinnitus Aspects

How long have you had tinnitus?

- | | | |
|--|-------------------------------------|--------------------------------------|
| <input type="radio"/> < 3months | <input type="radio"/> 1 to 2 years | <input type="radio"/> 10 to 20 years |
| <input type="radio"/> 3 to 6 months | <input type="radio"/> 2 to 5 years | <input type="radio"/> >20 years |
| <input type="radio"/> 6 months to 1 year | <input type="radio"/> 5 to 10 years | <input type="radio"/> Not sure |

Can you recall where you were or what you were doing when you first became aware of your tinnitus?

What do you consider to be the cause of your tinnitus? Does anything make your tinnitus better or worse?

Please describe the onset of your tinnitus.

- | | | |
|-------------------------------|------------------------------|--------------------------------|
| <input type="radio"/> Gradual | <input type="radio"/> Abrupt | <input type="radio"/> Not sure |
|-------------------------------|------------------------------|--------------------------------|

Please describe the sound of your tinnitus.

- | | | |
|-------------------------------|---|---|
| <input type="radio"/> Hissing | <input type="radio"/> Whistling | <input type="radio"/> Pure tone |
| <input type="radio"/> Ringing | <input type="radio"/> Humming | <input type="radio"/> Difficult to describe |
| <input type="radio"/> Buzzing | <input type="radio"/> Combination of sounds | <input type="radio"/> Other: |

Please describe the location of your tinnitus.

- | | | |
|---------------------------------------|--------------------------------------|--------------------------------------|
| <input type="radio"/> Left ear only | <input type="radio"/> Right ear only | <input type="radio"/> Both ear |
| <input type="radio"/> Inside my head | <input type="radio"/> Can't describe | <input type="radio"/> Left ear worse |
| <input type="radio"/> Right ear worse | <input type="radio"/> Other: | |

Please describe the frequency of your tinnitus.

- | | | |
|--------------------------------|-----------------------------------|------------------------------------|
| <input type="radio"/> Constant | <input type="radio"/> Fluctuating | <input type="radio"/> Intermittent |
|--------------------------------|-----------------------------------|------------------------------------|

What tinnitus treatment have you tried?

- | | | |
|---|---|--|
| <input type="radio"/> None | <input type="radio"/> Hearing devices | <input type="radio"/> Noise protection |
| <input type="radio"/> TMJ treatment | <input type="radio"/> Tinnitus apps | <input type="radio"/> Sound therapy (i.e. maskers / music / nature sounds) |
| <input type="radio"/> Psychotherapy (i.e. CBT / TRT Counseling / mindfulness) | <input type="radio"/> Music Therapy | <input type="radio"/> Medication (i.e antidepressant sleeping pills / antianxiety) |
| <input type="radio"/> Neuromodulation (i.e. transcranial / bimodal) | <input type="radio"/> Alternative therapies (i.e. reflexology /acupuncture) | |
| | <input type="radio"/> Other: _____ | |

Have you started any of the above treatments in the last 3 months? Yes No
What type of health care professional provides this treatment?

Prior to today, have you seen a healthcare professional about your tinnitus? Yes No

Have you been diagnosed with any medical conditions related or unrelated to your tinnitus? Please describe: Yes No

Do you regularly take aspirin? Yes No

Have you taken any new medication in the last 3 months? Yes No

Please mark any you have taken.

Quinine Quinadine Stretomycin Katamycinn Dihydroswptomycin Neomycin

Have you had an MRI regarding your tinnitus? Yes No

Was the outcome normal Yes No

SLEEP

How many hours of sleep do you get each night? _____

How soon do you fall asleep? _____

Do you feel refreshed or well rested when you wake up? Yes No

What medications, herbs, teas, etc. do you take to help you sleep?

PSYCHOLOGICAL

Have you ever experienced feelings of anxiety / stress / depression / or emotional struggles in general (prior to developing tinnitus)? Yes No

Have you ever experienced feelings of anxiety / stress / depression as result of your tinnitus? Yes No

Have you been clinically diagnosed with Anxiety? Yes No

Have you been clinically diagnosed with Depression? Yes No

Have you been clinically diagnosed with OCD? Yes No

Have you been clinically diagnosed with ADHD? Yes No

AUDIOLOGICAL

Do you feel you have hearing loss? Yes No Not sure

When was your last hearing exam? _____

What were the recommendations? _____

Do you currently wear hearing aids? Yes No
If yes... Both ears Right ear only Left ear only

If yes, were you fit in the last 90 days? Yes No

If no, but hearing aids are recommended, what treatment is a priority for you?

Tinnitus Hearing loss

Do you have trouble tolerating certain sounds? Yes No

Describe: _____

If yes, do these sounds cause physical discomfort? Yes No

Have you been diagnosed with hyperacusis? Yes No

Describe: _____

HEARING RISK ASSESSMENT

Have you ever...

Been exposed to gunfire or explosion? Yes No

Attend loud events? (i.e. concerts) Yes No Describe: _____

Had noisy jobs? Yes No Describe: _____

Have noisy hobbies or activities? Yes No Describe: _____

Had any surgeries involving your ear(s) or head? Yes No

Describe: _____

Have you used or worked with solvents, thinner or alcohol-based cleaning agents? Yes No

Describe: _____

Do you...

Have loose dentures, jaw pain, grinding, clenching sensation in the jaw? Yes No

Do you currently work? Yes No

What is your current occupation? _____

What was your past occupation? _____

What level of stress to you have? Low Moderate Severe

LIFESTYLE

How much caffeine do you consume daily?

- Coffee Chocolate Energy Drinks
 Soda Tea (black/green) Other: _____

Do you drink alcohol? Yes No Number of drinks/week: _____

Do you use tobacco? Yes No Amount/day: _____

How long have you used tobacco? _____ If you have quit, when? _____

Do you use recreational drugs? Yes No

If yes, describe: _____

Does your medical history include any of the following:

- Diabetes Radiation therapy to local area Compromised immune system
 TMJ Chemotherapy within 6 months Cognitive ability

EXERCISE

Do you currently exercise? Sedentary Light Activity Moderate Active Very Active

COMPENSATION

Are you currently pursuing any form of compensation, sickness benefit, DVA, motor vehicle accident claim or any other legal action relating to your tinnitus? Yes No

Describe: _____

LENIRE CONTRAINDICATIONS

- Pacemaker, defibrillator or any Other active implantable device (unless directed by a doctor)
- Pregnant (unless directed by a Doctor)
- Epilepsy
- Condition that may result in loss of consciousness
- Condition that causes impaired sensitivity of the tongue
- Lesions of the oral cavity (unless directed by a doctor)
- Sores of oral cavity (unless directed by a doctor)
- Inflammation of the oral cavity (unless directed by a doctor)
- Any intermittent or chronic neuralgia in the head/neck Area

CLINICAL OUTCOMES

What would be the first most successful treatment outcome for you?

- Tinnitus less bothersome
- Improvement in concentration
- Improvement in sleep
- Improvement in mood (anxiety/stress/depression/emotional)
- Improvement in hearing

What would be the second most successful treatment outcome for you?

- Tinnitus less bothersome
- Improvement in concentration
- Improvement in sleep
- Improvement in mood (anxiety/stress/depression/emotional)
- Improvement in hearing

What would be the third most successful treatment outcome for you?

- Tinnitus less bothersome
- Improvement in concentration
- Improvement in sleep
- Improvement in mood (anxiety/stress/depression/emotional)
- Improvement in hearing

MEDICAL CONTACT DETAILS

Name and Address of Primary Doctor: _____

Name and Address of ENT: _____

I give consent to release my results/treatment to my Primary Doctor / ENT.

PRINT NAME

SIGNATURE

DATE